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Deconstructing Professionalism as Code for White (Power): Authenticity as Resistance in Nursing

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ABSTRACT

The concept of professionalism is embedded into all aspects of nursing education and practice yet is rarely critically interrogated in nursing scholarship. This paper describes how professionalism in nursing is based on whiteness. When actualized, this oppressive construct homogenizes individuals' identities to assist nurses in building and wielding power against each other and against patients, and results in dehumanization and disconnection. Foregrounding an ethic of authenticity as a practice of resistance against white professionalism offers an alternative possibility for how nursing could be taught, practiced and theorized. As such a practice must begin with oneself, the authors outline a reflexive process from which to begin this work.

1 | Introduction

The project of nursing professionalization and its resulting expressions of professionalism are perennial, undying topics in nursing discourse. Critiques from within and outside of nursing have existed alongside strategic scholarship for just as long. O'Brien, in 1978, warned of the risk of assuming professionalization will do more for patients than establish power and financial gain for nurses (as paraphrased in Rutty 1998). French sociologist Pierre Bourdieu critiques the claims of neutrality of professions, arguing they have been naturalized into the 'social unconscious' as though they weren't built on power, epistemic struggles and political alliances (Bourdieu and Wacquant 1992). Turkoski (1995) exposes how the naturalization of professionalism discourse conceals 'elitism, disenfranchisement, subordination, issues of class, race and gender', as well as destructive approaches to service and altruism (p. 89). More recently, Valderama-Wallace and Apesoa-Varano (2020) named professionalism in service of whiteness as part of the hidden curriculum. Deleuze's notion of societies of control is invoked by Drevdahl and Canales (2023) and Dillard-Wright and Jenkins (2023) to describe the compulsory homogeneity and conformity resulting from decades of institutional, political and regulatory self-surveillance.

The project of establishing autonomy for nursing, a major theme in professionalization discourse, was understood to require a unified approach both in social and political strategy. The homogenizing and universalizing effects this had on the social construction of nurses and professionalism as an image and behaviour has been naturalized to invisibility in arenas like nursing education and regulatory principles and documents (Bell 2021). In this paper, we assert that nursing has yet to responsibly and ethically account for how the constructs of nurse and professionalism, together that are operationalized and at times violently inscribed, are constructs of white supremacy.

With this paper, we want to contribute to the deconstructive discourse on how nursing professional*ism* manifests as an oppressive construct of whiteness, even as it means finding and deconstructing its expressions in ourselves as three white

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women nurse educators. We are particularly interested in the role nurse educators have in reproducing white professionalism, as an oppressive *ism* in our teaching and in our interactions with students. No doubt there is irony in three white women submitting an article to a peer-reviewed journal about disrupting white professionalism; article production and metrics are materially valuable to our careers, which we want to acknowledge transparently. Further, collectively, we have spent 22 years as nursing students and 54 years as professional nurses so we are as entrenched in white professionalism as any. We gather together in a community of practice of sorts to name and deconstruct these mechanisms in ourselves and our work and are convinced of the importance of having this discussion discipline-wide.

Additionally, we seek to contribute to the conversation about what resistance in nursing can look like when it is aimed not at outside factors, but rather against the long-held assumptions and values we continually reify in nursing education and socialization. (Undoubtedly, the former is a more comfortable discussion for nursing to have.) A brief literature search on 'practices of resistance in nursing' reveals that most of the extant scholarship on this topic details nurses' resistance to organizational demands or change as a way to take moral action and assert agency within the healthcare hierarchy (e.g., Jackson et al. 2011; McMillan and Perron 2021; Peter, Lunardi, and Macfarlane 2004). We position our piece here as a companion, from a proactive rather than a reactive stance, and between/within rather than against/outside: practicing authenticity as a strategy for resistance against white professionalism as an *ism* in our teaching and practice of nursing. Our first act of resistance is to explicate this phenomenon and trace its deep tentacles. Our second act will be to explore authenticity as a practice of resistance against white professionalism in nursing education and practice, and to begin to imagine possibilities for what an ethic of authenticity could look like in our work.

Lastly, for context, we have consciously elected not to capitalize the w in White though we acknowledge the varied positions on the matter. We move to decentre whiteness and counter the glorification of what is conceptualized as the white race in extremist white supremacist discourse.

2 | Background

Professionalism is a required competency domain for nursing educational curricula across North America. Nursing's perspective on professionalism is built upon a specific concept of professional identity, which the International Society for Professional Identity in Nursing [ISPIN] defines as 'a sense of oneself, and in relation to others, that is influenced by characteristics, norms and values of the nursing discipline, resulting in an individual thinking, acting and feeling like a nurse' (2019). Both the American Association of Colleges of Nursing [AACN] (AACN 2021) and the Canadian Association of Schools of Nursing [CASN] (CASN 2022) delineate professionalism as a building block of nursing education and socialization in the profession. Along with adhering to laws, regulations and ethical principles in providing care, AACN's required professionalism competencies also dictate that nursing students must: '[exhibit] comportment reflective of nursing's mission to society' (p. 49), 'demonstrate adherence to a culture of civility' (p. 50) and 'demonstrate the core values of professional nursing identity' (p. 51). Maintenance of professional boundaries is captured under this umbrella as well, by both AACN and CASN.

There is very little discussion in the nursing scholarly literature or discussion space that critiques these aspects of professionalism (Drevdahl and Canales 2023). Ideas of comportment, core values and civility (non-questioning, compliance, receptivity) are assumed and taken for granted to be universally held and applicable. We suggest that insofar as professional identity allows nursing access to power, critique of professionalism constitutes a threat to the institution of nursing. The investment nursing organizations and educational institutions have in the discourse of professionalism serves to buffer this inherited 'folk concept' (Bourdieu and Wacquant 1992) from discipline-wide critique. And yet, to move our profession forward toward a truly antiracist future, this is exactly what we must deconstruct. Jackson (2023) notes that nursing education promulgates whiteness by enculturating whiteness inside professional values. Cerdeña et al. (2022) discuss how vague definitions of 'professionalism' imbue white, cisgender, straight and able-bodied standards to gatekeep the boundaries of belonging in healthcare education. Whiteness and professionalism are bound up together in nursing's codification of professional values—and, in turn, are enacted and operationalized in their re/enforcement by nursing educators.

3 | Deconstructing Professionalism

3.1 | Professional*ism* and Identity

Despite what much of nursing identity scholarship says, identity is a fluid and iterative process of constant social mediation based on socially assigned meanings of behaviour (Holland and Lachicotte 2007). In nursing to date, the only sanctioned identity seems to be a professional one. The nursing identity scholarship avoids any engagement with structural or cultural identities and thus communicates an assumption of homogeneity when this has never been the case (Bell 2021). Nursing materially and conceptually has homogenized identity to secure and advance social power; to attain and protect professional status. The calculated exclusion of people of colour, of lower class, and of non-Christian religions from the schools and ranks of nursing succeeded in building nursing power in its acquiescence to the oppressive norms of white supremacist Christian heteropatriarchy (Turkoski 1995) but also established a seemingly unshakeable cultural foundation in nursing that has us policing ourselves through constructions of professionalism that have nothing to do with competence and everything to do with the reproduction of the doxa of the professionalization project (for more on doxa see Bourdieu and Wacquant 1992). Professionalism and identity scholarship often describe professional identity development as a result of socialization into the culture and norms of nursing. A legacy of white supremacist colonialism is that whiteness dominates professional settings in Canada and the United States and it is in this environment that nurses and nursing students are socialized.

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Forever hopeful and obviously naive, we were each surprised in turn when we couldn't dig up nursing literature that takes up the concept of codeswitching. The concept of codeswitching originates in linguistics as the study of different dialects and mannerisms being employed by people in different contexts (McCluney et al. 2021). 'Code-switching is the act of changing or adjusting your language, accent, style of speech or behaviour to assimilate to the environment and people present' (Kusi-Appiah 2022, 1), while racial codeswitching relates to experiences of discrimination, stereotyping and systemic barriers (McCluney et al. 2021). To some degree, nursing professionalism demands that every nurse bend their behaviour, tone and appearance to match ideological constructions of the ideal nurse. Nursing professionalism goes so far as to demand, non-negotiably in some cases (Lipscomb 2024), that nurses not only conform to standards of appearance and behaviour, but that they also perform emotions such as compassion (Drevdahl and Canales 2023; Lipscomb 2024) to prove their professionalism. Where the dominant cultural and racial frames of nursing are entrenched in whiteness (Jackson 2023), nursing students and nurses may learn that 'sounding like a white person will confer positive reactions from others' while white people 'may negatively evaluate behaviours that do not reflect their own experiences' (McCluney et al. 2021, 8). McCluney et al. describe how racial codeswitching is employed in the workplace to make folks in the dominant group comfortable and is done in exchange for fair treatment because the white cultural norms of speech, dress, behaviour and language are associated with competence. People who don't fit the white professional mold not only have to attend to their actual nursing competence, but also to the chronic task of navigating impression management (McCluney et al. 2021): '... why am I expected to use words, a tone and mannerisms that are completely inauthentic to me in a profession that already demands so much? This is a second job that I did not sign up for' (Kusi-Appiah 2022, 1). As an educator I, Blythe, understand that I have inadvertently rewarded, and thus reproduced the need for, racial codeswitching in students by interacting most, or most easily, with those who are the most relatable to me. I understand this to be a function of my own social comfort both intrinsically as someone with social anxieties and also as a result of my socialization to comfort as a white person.

3.2 | Professional*ism* and Power

Key to the concept of white professionalism as employed—and weaponized—in nursing is deference to authority and hierarchy in our interactions, in the interest of gaining access to various forms of power. Drevdahl and Canales (2023) suggest that nursing's 'obsession' with professionalism works to access and maintain power both externally vis a vis medicine and internally to privilege some nurses above others. A key piece of the hidden curriculum in nursing education is teaching our students to build and wield power, against both each other and against patients. This phenomenon is sneaky; it hides within discourses of 'lifelong learning', 'providing quality care' and 'collaboration and partnering'. While on the surface, these discourses seem innocuous, in this section we unpack how these are employed in assertions of power.

3.3 | Building and Wielding Power Against Each Other

The structure of contemporary North American nursing education programs and licensure reflects the battle for power that occurs within our discipline, couched in the rhetoric of 'lifelong learning' and 'improving quality care'—starting with the structure of nursing education itself and how value is communicated to prospective applicants to nursing programs. In the United States, there are different types of nurses which represent a variety of levels of education and degree pathways, including Associate's, Bachelor's, Master's, Doctor of Nursing Practice and/or PhD (American Nurses Association n.d.). Canada also distinguishes types of nurses by level of education (Registered Nurses' Association of Ontario 2018). Recent initiatives to increase baseline education for bedside nurses, as well as to mandate a clinical doctorate degree for entry-level advanced practice registered nurses (RN) and nurse practitioners (National Organization of Nurse Practitioner Faculties 2023) illustrate the ongoing scramble in nursing over changing and increasing credentialing. This reinforces implications that nurses with fewer credentials are not as good, and reflects the rigidly hierarchical nature of nursing scope and consequently afforded respect.

A tangible example of how nurses and nurse educators socialize nursing students to believe and embody this hierarchy is a fourth-year student casually telling their classmates that their RN preceptor's role is to guide the licensed practical nurses (LPNs) working 'under' them because the LPNs don't have the necessary critical thinking skills. The assumption is that people with an LPN credential are not capable of the same cognitive processes as the people who are credentialed as an RN. We reproduce and wield this wholly incorrect narrative as a power to maintain value in the workplace and to communicate this hierarchy to incoming nurses.

3.4 | Wielding and Building Power Against Patients

The way we talk about patients in nursing education is similarly undergirded by assumptions of power and whiteness. One such example is the way nursing curricula teach students how to think about and navigate 'patient–nurse difference'. Even though cultural competency is outdated (Melino et al. 2023) and a host of other frameworks are now available to help [white] students think about inequity, it remains the dominant paradigm in nursing education in the United States. Many scholars have talked about nursing's use of 'culture' as a euphemism for race (Hilario, Browne, and McFadden 2018; Louie-Poon et al. 2022) as though culture is somehow a more palatable word (Collier-Sewell 2023). Not saying what we really mean is a form of exerting power. Keeping the professional discourse in the realm of culture and refusing to move it to speak about issues of race, class and religion prevents us from being able to meaningfully work with communities. We can never be true co-conspirators if we are not telling the truth to ourselves, our students and our patients.

A compounding problem is how dominant nursing education discourses attempt to subvert power dynamics by using words

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like 'partnering' and 'collaborating' with patients. The AACN (2021) Essentials: Core Competencies for Professional Nursing Education, the document that sets the curriculum standards for nursing programs across the United States, is rife with this language. The dominant paradigm in this area is built for white nurses instructing white nurses on how to work with 'marginalized' groups. This leaves our students who come from 'marginalized' communities and want to work with their own communities without strategies and support. As an educator, I Kate) have found that white nursing educators lack the language and capacity to discuss how to work with oppressed communities when students are also part of that community. Collectively, we have observed that dominant (white, cis, heterosexual, middle-class) nursing education discourse doesn't know how to step outside of this—and, on the occasion that it may, it relies upon people of colour to educate white nurses on the topic, representing another form of colonialism. A subthread of this occurs when white professional nursing *is* able to step outside this boundary, the 'marginalized' student working with 'marginalized' patients/communities becomes represented as a wholly positive and easy endeavour, without nuance. This serves to further alienate 'marginalized' students because the reality is not so simple; while it may be straightforward in some ways, working with a community you are a member of comes with its own set of challenges. Healthcare scholars such as Bennett, Zubrzycki, and Bacon (2011) have highlighted that [white professionalist] conceptualizations of boundaries, maintaining confidentiality and limiting self-disclosure with patients are often in conflict for 'marginalized' clinicians working with people from their own community because of shared community values and responsibilities. Cerdeña et al. (2022) call for a reshaping of professionalism in medicine that centres both patients and trainees currently in the margins. Such a reshaping is in dire need in nursing as well. A result of working to stand apart (being/becoming professional) is that we must teach how to come together without looking like we made ourselves self-important. How can we as nurses reconcile feigning collaboration or equal partnership (as we do when we extol the virtues of community-based participatory initiatives) while still holding onto power?

3.5 | Professional*ism* and Dehumanization

Nurse educators are tasked with cultivating students' professional practice, and subsequently identity, through prescriptive standards that we contend upholds dehumanizing practices. Goldberg (2008) interrogates the concept of professionalism in medicine, revealing how humanism and professionalism are not correlative. Humanism is delineated by notions of universality, egalitarianism and an obligation to human society, whereby humanitarian acts are motivated by the welfare of others. Although humanism in nursing is broadly assumed and not clearly defined, it implies an authentic connection between the nurse and patient (Létourneau, Cara, and Goudreau 2017). Contrary to humanistic ethos, Goldberg counters that professionalism offers an elite identity and socialization into the discipline that favours self-promotion. If professional members do not acculturate successfully to the group, condemnation results. Likewise, Dillard-Wright and Jenkins (2023) address professionalism in nursing, identifying the institution as 'exerting absolute control over every aspect of life for individuals and all operations in service to the institution itself' (p. 2). Deviation from professional expectations enables nurses with or without authority to enforce boundaries through policing efforts (Cerdeña et al. 2022; Dillard-Wright and Jenkins 2023). This incongruency between humanism and professionalism should be at the forefront of critical discourse in nursing.

Conformity to professionalism, learned in the policies outlined in student handbooks, is understood as essential for students to be successful throughout the tenure of their education. However, a steep price must be paid; students must lose or distort their identity to gain entrance to the collective identity of a professional nurse (Dillard-Wright and Jenkins 2023). Assimilationism, a strategy employed in hegemony, necessitates the devaluing of the individual self to advance one's (professional) personhood. A form of colonialism that is widely acceptable in the social contract of the United States, assimilationism promises an opportunity to become 'fully developed' as a human being (Kendi 2019). Students are convinced to participate in this dehumanizing process by masking their authentic selves, as being oneself is not deemed 'enough'. Contradiction resounds as students are taught to respect patients, suspend judgement and meet patients where they are, yet students are not always given this same consideration. Real loss is felt when one must 'sever parts of [their] lives' (Cerdeña et al. 2022, 573) to fulfil a professional role. So powerful is this conditioning that while students engage in professionalism, building skills that connect them intimately with their patients and their physical bodies, students often become disembodied from their own. I (Kaija) witness this as an educator when I ask students how specific nursing curriculum lands in their body or connects to their feelings and emotions. Students usually respond with either look of confusion or rely on a more familiar approach to intellectualization.

3.6 | Disconnection From Self

When one's human experience is disregarded in the professionalization project, it is unsurprising that this could lead to disconnection from self—somatically, emotionally and spiritually. In the classroom, we have recognized that the dissolution of oneself as imposter syndrome. Imposter syndrome (or imposter phenomenon) manifests as internalized intellectual phoniness through which students are distressed by their inability to attain 'perfectionism with ease' (p. 243); this phenomenon is rooted in professional and social expectations (Clance and Imes 1978). The imposter identity is commonplace in nursing education and likely a byproduct of identity erasure within the professionalization process. When students try to disrupt this process by calling attention to feelings of imposter phenomenon, I (Kaija) have personally deflected critical discourse and instructed students to accept this expected norm in nursing school. I, the colonizer, 'comforted' them by highlighting that they are not alone in their unease, as I am asking the entire class to assimilate to the professional culture. Thus, conformity and perfectionism take hold (Dillard-Wright and Jenkins 2023), leaving students exasperated, grasping to reach unsustainable, grandiose ideals and standards for a nursing degree and career. So successful and great is this

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burden that we've observed students parrot disciplinary language, speech and tone to sound like a nurse, submitting essays that use all the 'right words' but convey empty meaning. As nurse educators, we find it difficult to then decipher the authentic voice, identity or ideas of the newly professionalized student.

3.7 | Disconnection From Community

The masking of identity, whether utilized in everyday contexts or solely employed in school and healthcare work environments, creates risk for students and nurses not only in isolation from self but also from others. When considering the professional nurse culture, 'human relationships must adapt to a tight and inflexible hierarchy; [where] humanism is rationed out in ways that don't interfere with the healthcare engine' (Goldberg 2008, 718). Without authenticity of self, false connections occur in interpersonal relationships where nurses master the 'professionalism role' and fake kindness abounds. Contandriopoulos et al. (2023) described fake kindness as performative; nurses engage in visible displays of compassion that advance one's interests (or rather the profession's interest.) With the aid of disassociation, the nurses' behaviour and tone, grounded in white professionalism, are weaponized as 'a tool of social discipline and a manifestation of internalized hierarchies' (p. 4). Depicted by false, rigid smiles and eerily calm, soft voices, hegemony is strategically wielded by the nurse and supported and enforced by the institution. No longer motivated by the welfare of others, dehumanizing professional practices like this result and the community suffers. I, Kaija, have tried on and successfully employed a mask of fake kindness to manipulate what I want from my colleagues, students and patients. Using 'niceness with a purpose', without my heart, I do this in service of external validation and furthering my career in academia, especially while in tenure track, without much regard to how this could sabotage my relationships with others. Jackson (2022) describes how a code of niceness breeds toxicity and inauthentic engagement in nursing and enables nurses to avoid conflict when fake kindness is called to attention. I may convince myself that no one is privy to this act of professionalism I play, going to great lengths to hide it even from myself, however those who maintain authenticity can easily read my inauthenticity.

Much like fake kindness, the concept of civility is wrapped up in how a nurse is deemed good or at least appears good (Contandriopoulos et al. 2023). Civility, defined as conduct that is polite and civilized (Merriam-Webster 2024), assumes a safe work environment upholding human dignity and respect (Clark 2017), although one could ask: safety, dignity and respect for whom, as these cannot be assumed without interrogating (white) power (Freborg and Clark Chalmers 2024). Civility is a competency of nursing professionalism identified and mandated in the AACN essentials and when successfully executed, allegedly demonstrates nurse accountability to society and the profession (AACN 2021). School statements on civility are encouraged with the intention towards the socialization of the nursing student into the profession (Clark 2017). Despite the goal of civility, many of these university statements and policies focus primarily on incivility providing rationale for punitive measures such as expunging students from programs who are not considered a good 'fit'. The American Nurses Association (2015) position statement on 'Incivility, Bullying and Workplace Violence' outlines that nurses abide by a 'culture of civility and kindness' (p. 1), as the profession will 'no longer tolerate violence of any kind from any source' (p. 1). This is a confounding declaration when examining fake kindness and civility through a humanistic lens, as these professional behaviours often negate authentic relationships with self and others, resulting in disconnection.

4 | Discussion

The implications of continuing to feed the white professionalism project of nursing are clear: we have described how current constructs of professionalism erase identity, dehumanize, exclude, disconnect and cover over power dynamics between nurses and patients/communities that must be critically interrogated. This leaves us grappling with our role as educators, taking pause on whether or how we should be teaching professionalism to our students while aware of dehumanizing ramifications. There are many reasons why educators may include professionalism in our pedagogy: to ensure professional and organizational guidelines are followed, to prepare students for current practice, or to help students, particularly those 'marginalized', to avoid harm. We also appreciate Buckler (2023) perspective on what 'playing the game', or going along with, with respect to professionalism affords us as nurses and as nursing educators, even as we hold these critiques of the environment in which we play. Playing the game gets us 'access, leverage, legitimacy and funding' (p. 1824) from the status quo upon which, once obtained, may allow us to begin to practice small acts of subversion from the inside. While this approach is not without pragmatism, like Buckler (2023), we have serious reservations about whether the small wins and short-term gains from this approach make the harm-benefit calculation worth it.

4.1 | Resistance and Authenticity

This leads us to ask: what might we envision as an alternative to socializing our students into these harmful and antiquated constructs? How can we practice resistance against white professionalism as an oppressive construct in our nursing education work? As mentioned earlier in the paper, a literature search on 'resistance in nursing' largely reveals research on why nurses resist change—and so we look to literature on resistance in healthcare overall to help point the way. Essex (2021) conceptualizes resistance as fundamentally a response to power (in this case, white power) and as actions that can take many forms and involve various constellations of actors. He notes that resistance in healthcare has a particular flavour: in contrast to general feminist and Foucauldian conceptions of resistance, healthcare professionals do not necessarily inhabit a subaltern position in resisting against unjust structures, practices or policies; often, they are the very people tasked with inscribing these unjust practices onto people's material bodies during their 'everyday' delivery of care. As nursing educators, we take up the same position vis a vis our students.

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Black feminist education scholarship holds ideas for us as well. In *Teaching to Transgress*, hooks (1994) offers guidance on how to practice authenticity in teaching that is applicable to nursing education. hooks (1994) outlines the process by which educators can actualize an engaged pedagogy. Such a pedagogy requires that professors also be vulnerable and commit to growing alongside their students in the classroom. This is a radical act in academia: to situate self as nonexpert and to allow for co-creation of the learning space versus its imposition. The way white-coded professionalism and competence are constructed as co-dependent creates an environment of risk for educators to situate themselves as nonexperts, and students are socialized to nursing in this toxic environment. Of course, we don't naively suppose that vulnerability on the educator's part precludes them from causing harm to students, particularly when our lack of expertise centres on antiracism, anti-oppression broadly, or our own tacit reinforcements of white professionalism.

Here, we begin to explore authenticity as a practice of resistance against white professionalism as an oppressive ism in nursing education and socialization. We could find only a few articles from nursing on authenticity as a standpoint, ethic or practice of resistance, and fewer still that divorced authenticity from 'professional competence' (see, Collier-Sewell and Melino 2023; Daniel 1998; Nosek 2012; Starr 2008). We engage with practicing authenticity as a move that recognizes the full humanity of a nurse beyond service to the patient in a professionalized therapeutic encounter, and that we lose more than we gain by prescribing via professionalism what the possibilities for the nurse's expression of full humanity can be. This is not to be confused with therapeutic use of self, or use of self as a tool of intervention, as is often taught in nursing programs, which is a highly performative and proscribed self that is used as a means to an end (patient change). We have witnessed the use of therapeutic self in motivational interviewing to feign interest and build trust with patients leading to manipulation in care for the sake of outcomes. This kind of weaponization of self does not align with engaging with one's full humanity.

A practice of authenticity asks educators to possibly lean into discomfort, away from previous notions of professionalism. One may take risks in sharing their experiences of cognitive dissonance in relation to nursing content like the teaching of professionalism or they may share their own 'unprofessional' acts, such as past drug use or sociopolitical disruption leading to legal repercussions, to reveal their humanity. These radical moves, enacted within boundaries of safety, have the capacity to build a connection between educators and students, as students may begin to better see themselves in their professors. It also opens a space for students to take on mutual risk to be fully themselves in the classroom. We acknowledge here that the mutual risk we're talking about does not mean equal risk for students or faculty when we consider how differently everyone is positioned socially and structurally by their claimed or ascribed identities.

As we mentioned above, we belong to a community of practice generated from feelings of isolation related to antiracist education, discourse and practice in nursing. Following the publication of an article of mine (Blythe) I was contacted by several people, drawn by the use of explicit language around white supremacy and racism in nursing, and the open critique of our weaponization of whiteness. Each person, in turn, expressed isolation, backlash or unsafety in resisting or having frank discussions and conducting research about whiteness and racism in nursing. Participants of my 2021 doctoral study similarly reported having *no one* in their schools of nursing they could safely have frank discussions about whiteness and racism with (Bell, 2023). The opportunity to have authentic conversations, ask questions of ourselves and others, learn together and support each other towards making nursing education antiracist was sorely missing. We gather monthly across many time zones and three countries, currently, to digest our experiences, reflect on our teaching and research and interrogate how white supremacy operates through and around us, specifically in the nursing education environment. This space of authenticity and vulnerability is generative. Where experiences and the cognitive dissonance around the weaponization of professionalism towards ourselves and our students are validated by our peers, we are emboldened to resist together in the community. In an environment where critique and critical reflexivity are not constrained by whiteness and white fragility, we can strategize.

We pause our sharing here as a point at which to invite others into this conversation. In the initial drafts of this article, we offered suggestions for solving this issue at various levels of intervention and then laughed as we recognized our institutional capture (Smith 2005) and erased it all. Borrowing this concept from institutional ethnography, institutional capture refers to the ways in which dominant systems of ruling socialize and 'capture' our experiences, work and thinking in insidious ways that serve their own interests (Smith 2005). As nurses, our socialization into a profession that values and rewards concrete actions and implementable solutions runs deep—and so here, pausing and percolating is also a practice of resistance. To quote Dillard-Wright (2024), 'why is it that always always always, when point [sic] out flawed realities in service to thinking, imagining, dreaming different present/futures, it is always about IMMEDIATE solutions? Maybe urgency is part of the problem'. In an act of resistance, we choose instead to slow down, disrupt our reflex to produce and sit in the struggle of our unknowing (Menakem 2017). Thus, we offer a seat in critical inquiry to reconcile with the full impact of the professionalization project.

4.2 | Reflexive Questions to Imagine a Practice of Authenticity in Nursing Education

1. How do I resist policing behaviour according to white professionalism?
2. How am I rewarding codeswitching behaviours in my student engagement?
3. What activities can I use to engage and learn about students beyond their 'student nurse' identities?
4. How do I respond to the power of keeping to a content-packed agenda? How could this be disrupted to better support students?
5. Reflect to a time and place when I could fully be myself—What did this feel like? Has this ever been in a nursing environment?

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6. How can I support my students' authentic well-being? How does my pedagogy or curriculum contradict this?
7. How do I wield power in the classroom? How is it hidden in my curriculum?
8. What steps am I taking towards risk and vulnerability in my teaching practice?

5 | Conclusion

While the audience, venues and interest in putting forth critical antiracist nursing scholarship have expanded in recent years, deconstructing nursing's professionalism project and showing its inextricability with whiteness remains nascent (marginal?) in our profession's scholarship. The 'sacred cow' of professionalism in nursing is one that must be critically interrogated if our profession is to actually act upon the many words that have been spilled since 2020 towards creating an anti-oppressive future. Nursing literature often describes practices of resistance in nursing as defined against a dominant other—medicine, healthcare leadership, the patriarchy and so forth. Here, we call for nursing to resist against itself: what has become and latched onto in the name of asserting and maintaining power—a practice of resistance against our professionalization and the assumptions that underpin this endeavour. Foregrounding an ethic of authenticity in our practice—one that allows for the full humanity of the nurse—allows us to think through possibilities for the future outside of this ouroboros of professionalism.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data sharing is not applicable to this article as no data sets were generated or analysed during the current study.

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